The Honorable Ulysses Currie, Chair
Senate Budget & Taxation Committee
Miller Senate Office Building, 3 West Wing
11 Bladen Street
Annapolis, MD 21401-1991

The Honorable Howard P. Rawlings, Chair
House Appropriations Committee
Lowe House Office Building, Room 131
84 College Avenue
Annapolis, MD 21401-1991

The Honorable Thomas M. Middleton, Chair
Senate Finance Committee
Miller Senate Office Building, 3 West Wing
11 Bladen Street
Annapolis, MD 21401-1991

The Honorable John Adams Hurson, Chair
Health and Government Operations Committee
84 College Avenue
Annapolis, MD 21401-1991

Re: 2003 Joint Chairmen's Report – Consolidation of existing network of State-run psychiatric hospitals, MOOL, page 124

Dear Chairmen:

As requested by the *2003 Joint Chairmen's Report*, the Department of Health and Mental Hygiene (DHMH) is submitting this report regarding the reconfiguration of hospital bed space within the Public Mental Health System and planning for a network of State-run psychiatric facilities that includes only two large regional hospitals. If the consolidation option is pursued, the Executive and Legislative Branches will need to work closely together.

With the submission of this report, DHMH would like to request the release of $2 million in general funds. In the 2004 budget bill, the General Assembly restricted these funds until the report was submitted. If you have any further questions or concerns regarding this report, please contact me at (410) 767-6505 or Brian Hepburn, M.D., Director of the Mental Hygiene Administration at (410) 402-8452.

Sincerely,

Nelson J. Sabatini
Secretary

cc: Ms. Arlene Stephenson
Ms. Tracey DeShields
Dr. Brian Hepburn
Ms. Stacey Diehl
Ms. Jean Smith
Ms. Robyn Elliott
Mr. Dan O'Brien
Mr. James Johnson
Ms. Elizabeth Barnard
Ms. Karen Black

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Report to the Joint Chairmen
On
Maryland's Public Mental Health System

"RESTRUCTURING THE SYSTEM OF HOSPITAL CARE"

October 2003

Robert L. Ehrlich, Jr., Governor Michael S. Steele, Lt. Governor Nelson J. Sabatini, Secretary

Executive Summary

This document serves as the report requested pursuant to the 2003 Joint Chairmen's Report ML. 01.01.01, page 124 provides:

"…The State shall develop a network of State-run psychiatric facilities to include two, rather than three, large regional hospitals while maintaining existing bed capacity… the plan shall include proposed bed capacity by facility and a detailed time-line on the transition necessary to achieve reconfiguration."

The options considered include the consolidation/closure of Springfield, Spring Grove, or Crownsville Hospital Centers. Based upon the factors and time-line detailed in this report, the Department of Health and Mental Hygiene (DHMH) proposes the consolidation/closure of Crownsville Hospital. This will provide for the required restructuring of the State-operated system for inpatient care with the least disruption to patients and staff. Addi-tionally, a recommendation has been made to explore the option to privatize the Walter P. Carter Center. The report also suggests moving all acute care from the State hospital system to the private sector.

The report reviews options for the reconfiguration of the hospital system that meet current and anticipated service needs. Each option focuses on maintaining JCAHO accreditation, current bed capacity, and producing capital and operating savings. A brief overview of the Public Mental Health System's (PMHS) hospital system, bed capacity, and the pros and cons on the closure/consolidation of each facility are also provided. In addition, action steps and a timeline to achieve closure/consolidation are contained in the report.

Introduction

The Department's psychiatric hospital system is an essential provider, comprising 46% of all psychiatric inpatient beds in the State. In considering the closure/consolidation of a State facility, ensuring sufficient bed capacity to meet current and future demand was an integral part of the review process. Examination of Central Maryland's State psychiatric hospitals was the beginning point in the discussions regarding the transformation or reconfiguration of the State's Public Mental Health System. The three Central Maryland regional hospitals are Spring Grove Hospital Center in Catonsville, Crownsville Hospital Center in Crownsville, and Springfield Hospital Center in Sykesville. The Walter P. Carter Center, as part of the Central Maryland region (located in Baltimore City), and a key component in the hospital admissions process, is also considered in the report.

The leadership from all State-run psychiatric hospitals was involved in analyzing information and providing input for the report. Guiding principles during the analysis were that quality of care be maintained or improved, current bed capacity maintained, and capital and operating savings achieved. Extensive data on admissions, the variety of populations served, forensic involvement, bed-capacity, insurance status, geographic origin, staffing concerns, and many other factors were also considered. Additionally, the State's role as a manager of and payer for services was extensively reviewed, including the State's role in encouraging private sector participation in the delivery of mental health

services for the population groups currently served. This process was a data-driven process that led to the options discussed within this report.

Current State Psychiatric Hospital System

The Mental Hygiene Administration (MHA) operates eleven State psychiatric facilities—Springfield Hospital Center in Carroll County, Spring Grove Hospital Center in Baltimore County, Crownsville Hospital Center in Anne Arundel County, Eastern Shore Hospital Center in Dorchester County, Upper Shore Community Mental Health Center in Kent County, Thomas B. Finan Center in Allegany County, Walter P. Carter Center in Baltimore City, Clifton T. Perkins Hospital in Howard County (Jessup), and three Regional Institutes for Children and Adolescents (RICAs), which are residential treatment centers (RTCs) for children and adolescents located in Montgomery, Baltimore, and Prince George's counties. In the past, each hospital served defined geographic catchment areas, but with the tremendous demand for services experienced over the last few years, the hospitals no longer have catchment areas. Each hospital now serves patients from all over the State. The State hospitals provide acute, intermediate and long-term inpatient, as well as residential services (i.e., assisted living). In addition, Clifton T. Perkins Hospital Center provides both maximum and minimum security for individuals charged with the more serious crimes transferred from the Department of Corrections, or who may otherwise require the structure of maximum security. The individuals served by the State facilities usually have serious mental illness and do not have health insurance. The individuals may be committed by a court for evaluation or after a finding of incompetence to stand trial or not criminally responsible. In addition, the patients are received from emergency rooms, acute psychiatric units in general hospitals, freestanding psychiatric hospitals, jails or the Department of Corrections. It is important to note that the State is the only provider of long-term inpatient services and that the private sector provides limited intermediate care.

The State employs over 3,100 individuals in the eight (8) hospitals. If a facility consolidates/ closes, the State prefers that clinical staff and some of the administrative staff transfer with the patients to the receiving facility. In addition, to the extent possible, staff will be offered positions in other State hospitals. The hospitals are landlords to dozens of tenants, including private non-profit organizations and other State agencies that rent space on their campuses. Lastly, most of the State psychiatric facilities provide active training for many mental health disciplines, enhancing the clinical workforce. These include formal programs for under-graduate, graduate, and post-graduate studies.

Background on Bed Capacity

Over the past decades, MHA has dramatically downsized its hospitals. The number of inpatient beds, excluding assisted living beds, operating in Maryland's State psychiatric hospitals declined by 73% from 4,390 in 1982 to the current budgeted capacity of 1,204 (see Appendix i). The downsizing in the State system was due to several factors, including improvements in psychiatric medications, growth in community-based services, and most recently, efforts pursuant to the *Olmstead* decision that persons are to be placed in the least restrictive setting. However, in recent years, the Public Mental Health System has experienced an increase in demand for services, including inpatient level of care. The overall State psychiatric hospitals' occupancy rate is 98%. There are increasing numbers of individuals in emergency rooms certified as needing inpatient psychiatric care. Likewise, there is a waiting list for individuals requiring transfer from private

psychiatric units to a State hospital and a waiting list of individuals court-ordered to a State hospital for evaluation and/or treatment. Forensic (court involved) patients have longer lengths of stay than do other patients because discharges depend not only on clinical improvement, but also on the consent of the criminal justice system. As this population continues to grow, there will be less capacity to take admissions from emergency rooms and other sources.

Over the past five years, the forensic population in the State psychiatric facilities has increased from 38% to 49%. The number of individuals committed annually is increasing, which is reflected in the growing number of beds occupied by forensic patients. In FY 1997, 146 patients designated as "Incompetent to Stand Trial" (IST) or "Not Criminally Responsible" (NCR) were committed to Mental Hygiene Administration (MHA) facilities. By FY 2003, that number had risen to 246 patients, a 68% increase. In order to alleviate some of the pressure on the availability of beds both at Clifton T. Perkins and the regional hospitals, construction of an addition with a 48-bed maximum-security unit at Clifton T. Perkins Hospital has been proposed.

The following table provides a breakdown of the number of forensic patients at each facility since 2000. If this current trend continues, the percentage of beds that will be occupied by forensic patients will increase to 66% by FY 2009.

Hospital Forensic One-Day Census

FY 2000- FY 2003

Hospitals	*2000*	*2001*	*2002*	*2003*
Walter P. Carter Center	24	16	26	13
Thomas B. Finan Center	12	16	22	15
C. T. Perkins Hospital Center	197	202	207	203*
Crownsville Hospital Center	76	90	83	78
Eastern Shore Hospital Center	19	15	23	34
Springfield Hospital Center	77	81	72	86
Spring Grove Hospital Center	99	99	109	150
Upper Shore Community Mental Health Center	4	2	0	1
Total	508	521	542	580

** An additional 14 patients were "voluntary" commitments and did not have an IST or NCR status.*

There is an additional factor that may affect bed need in the next few years. The State of Maryland has had an Institution for Mental Disease (IMD) Waiver since 1997. This waiver allows for Medicaid payment to freestanding psychiatric hospitals for the inpatient treatment of adults, ages 21-64, with Medicaid. The Center for Medicare and Medicaid Services (CMS) has indicated to MHA that

this waiver will probably not be extended beyond FY 2005. As a result, the State would lose the federal match for these services. Without the federal match, it will be cost prohibitive for the State to cover the complete cost for inpatient treatment in IMDs. Without the State being the payer, it is expected that IMDs will be reluctant to serve adult Medicaid recipients. This will put increasing pressure on the State psychiatric facilities and/or increase the State dollars expended for this service. There are approximately 1000 adult Medicaid eligible admissions annually to IMDs.

At minimum, maintaining existing bed capacity to meet current demand is critical in any consolidation effort. The consolidation/closure of a State psychiatric facility should include the transfer of all of that facility's beds to other facilities in order to maintain the overall capacity. In addition, there needs to be flexibility in the system to accommodate the increase in bed pressure that may result if the IMD waiver is not extended beyond FY 2005 and if the forensic population continues to grow. This flexibility will not only address current demand, but to some degree, increased demand in the future. The Department projects that additional inpatient beds could be made available for utilization for all populations served, after some physical plant upgrades were completed and if the beds were funded.

Summary of Issues Relating to Any Consolidation

There is existing capacity in the system to absorb patients if a hospital is consolidated/closed. Each facility has submitted a proposal on how many additional patients it can safely serve, given some renovations and funding. Together, the current eight facilities project that 1,694 beds could be available, excluding assisted living beds. If Crownsville is consolidated/closed, the available bed capacity decreases to 1,370 beds from the above-stated 1,694 beds. If Spring Grove is consolidated/closed, the available bed capacity drops to 1,279 beds. If Springfield is consolidated/closed, the available bed capacity is 1,336. As shown in the table in Appendix i, entitled "Current Bed Configuration", if Crownsville (with an average daily population in FY 2003 of 197) is consolidated/closed, 352 beds, with renovations and funding could be available in the system to absorb the patients from Crownsville (based on 98% occupancy).

There are several factors that affect patient transfer plans and the use of available bed capacity. In considering the closure of a facility, multiple issues were addressed. Concerns raised related to:

Patients: A move results in the disruption of existing residences, support systems, and treatment programming. For short-term patients, this is less of an issue, but for the longer-term patient it is a considerable issue.

Families: The increased distance from the hospital where the patient is being treated to where the patient's family/friends reside, increases the possibility of their support being lost. The increased distance may impede regular visits and active involvement in the patient's treatment, and timely, successful discharge planning.

Staff: A move results in the disruption of functioning teams, which are currently organized to provide programming to specific units. There is no guarantee that staff will move with patients. Staff may opt to change job locations, but if they do not, facilities may face recruitment and training issues. Of particular concern is the possibility that nurses may choose to retire rather than transfer. Out of a total

of 3,100 hospital staff, approximately 600 are currently eligible for retirement with another 600 eligible within five years. The Statewide nursing shortage may compound recruitment problems and the ability to staff new units.

Community Issues: One of the major strengths of the State hospital system is that each hospital is community-based. This promotes direct family involvement in patient care and treatment, a sense of ownership and commitment by the local communities and community providers, and easier access by patients to pre-discharge transition services in the community. Consolidation and/or closure of a State psychiatric facility may result in less local commitment, such as a decrease in local groups volunteering in the facility. Decreased access to pre-discharge transition services may lengthen hospital stays.

Legal System: The court system and the detention centers are primary customers of the Public Mental Health System. They request and receive inpatient and outpatient evaluations regarding competency and responsibility, as well as treatment of defendants/inmates pre- and post-adjudication. A facility closure will result in increased travel time and possible increased safety risks related to transporting inmates (i.e., police officers must be used). Additionally, MHA staff must attend court proceedings. The increased distance related to carrying out these duties increases the length of time staff are off hospital grounds, thereby limiting hospital staff resources in performing other essential duties.

Tenants: The relocation of tenants who are housed on the hospital campus will create both logistical and financial burdens. The majority of tenants on all three campuses are either State/county agencies, or private, non-profit entities providing related mental health or substance abuse services. Appendices vi and vii provide a list of tenants. The cost savings reflected by the consolidation of State hospital facilities do not take into account the costs related to the ongoing operations of the non-State agency tenants. The hospitals provide services to these tenants; thus, if tenants remain, new Memorandum of Understandings (MOUs) would need to be created concerning services, such as utilities, security, and maintenance.

Programming and Space: The plans include moving individuals to space that will need improvements (renovations) before it is suitable for inpatient care. This will result in an initial expense to prepare the new accommodations.

Maintenance of Land/Buildings: Until the property is sold/transferred, there would be ongoing costs, such as heating, water, ground maintenance, security, etc.

Consolidation/Closure Options

Option #1: Consolidation/Closure of Crownsville

Crownsville Hospital opened in the early 1900s as an inpatient psychiatric hospital for the State's African-American residents. It is believed that the property has good real estate potential. Crownsville has more private, non-profit tenants than Spring Grove. A cemetery for patients and staff is on the campus and has been recently renovated. The hospital currently serves 200 patients. If this hospital were closed, the 200 patients would be relocated to four other DHMH psychiatric hospitals, with 90% of them remaining in the Central Maryland region. Public transportation is not available from the Crownsville area for staff or families to travel to other locations. Closure of Crownsville could result in layoffs of up to 147 non-clinical full-time equivalent staff (FTEs).

Option #2: Consolidation/Closure of Spring Grove

Spring Grove Hospital Center is the second oldest psychiatric hospital in the United States. The oldest buildings on the campus date back to the 1870s and are of significant historical interest. Two assisted living units on the campus could be privatized with funds being transferred with the residents. Closure of Spring Grove would result in the greatest savings to the State (see Appendix iii). Since it is the oldest campus, it is also in greatest need of modernization and renovation. The average daily population (ADP) for FY 2003 was as high as 273. Closure would result in patients being relocated to five (5) other DHMH psychiatric hospitals. Thirty-six (36) of those patients would leave the Central Maryland region, possibly putting family involvement in jeopardy and reducing continuity of care programming. Spring Grove is near public transportation, facilitating access for both families and employees. A closure of this facility could result in layoffs of up to 301 non-clinical FTEs. Spring Grove houses the only state-of-the-art medical/surgical building within the State system, the Smith Building. Relocation of this medical/surgical unit would be costly. Furthermore, Spring Grove houses many tenants, including 5 administrations within DHMH and the Maryland Psychiatric Research Center (MPRC). Relocation of the DHMH and MPRC tenants would be extremely costly to the State. Although the property has very good real estate potential, numerous wetlands limit the acreage that is useable.

Option #3: Consolidation/Closure of Springfield Hospital Center

In examining factors related to the three large regional hospitals, there were compelling reasons to keep Springfield Hospital Center open. There is, therefore, no further discussion of Springfield in this report. The rationale for this conclusion is as follows:

1. The physical plant has already been consolidated into the central segment of the campus. Modernized renovations are either in process or have been completed, including:

    - ?? Each building has an independent HVAC system, completed through an energy conservation project funded through Springfield's operating budget.

    - ?? The water system is in the process of being completely renovated and will be completed by the end of calendar 2003.

- ?? The electrical distribution system is being renovated and will be completed by the end of FY 2004.

- ?? A new dietary building has been approved and will be constructed in FY 2004.

2. The five patient buildings are in excellent condition. Two of the buildings (Hitchman1980, Salomon 1990) are the newest inpatient State psychiatric beds of the three large regional hospitals.

3. Closure of Springfield would require the relocation of 325 patients.

4. Springfield's capital needs are far less than Spring Grove's or Crownsville's.

   Current Capital Budget Requests are:

Springfield	Spring Grove	Crownsville
$7,802,000	$117,234,000	$98,060,000

   **Note: Figures are based on a maximum number of beds (388), which assumes no other beds in the system are used. Under the proposed restructuring of the system, the number of beds needed and the capital costs associated with those beds will decrease.*

5. Workforce
   - ?? More staff would be displaced by closure than at any other hospital.
   - ?? Fewer employees are eligible to retire; therefore, more lay-offs are likely.

6. Springfield, Carroll County, and the State have already maximized the real estate marketability by moving most of the facility to one area on the campus and transferring the majority of the remainder of the property to Public Safety & Corrections and the Town of Sykesville.

Comparison of Options

The charts below indicate the number of patients that would be transferred to other facilities in the two consolidation/closure options. If Crownsville is consolidated/closed, 200 patients are affected and 8 new units would need to be created. If Spring Grove is consolidated/closed, 250 patients are affected and 12 new units would need to be created. The new units that will be created as a result of either change will require some additional funds for renovations to accommodate the transferring patients' needs. Renovation and relocation costs would be higher under the Spring Grove Hospital consolidation/closure option. Additionally, disruption of clinical care and administrative staffing issues are greater with the consolidation/closure of Spring Grove Hospital, due to the higher number of patients and staff potentially affected.

Further pros and cons related to the consolidation/closure of either facility, Crownsville Hospital Center or Spring Grove Hospital Center, are located in Appendix iv.

Major Factors by Consolidation Option*

	Crownsville Consolidation/Closure	Spring Grove Consolidation/Closure
Geographic Access	200 patients transferred with 90% remaining in Central Maryland. Crownsville has limited public transportation.	250 patients transferred with 85% remaining in Central Maryland. Spring Grove is near public transportation providing some accessibility for staff and patients' continued family support; it also has close proximity to the University of Maryland for Maryland Psychiatric Research Center.
Tenant Issues	Heating and utilities independent of hospital operations. Many private non-profits.	Heating and utilities on central hospital system. Significant number of State-funded agencies, and the Maryland Psychiatric Research Center.
Staffing	Up to 147 non-clinical FTEs could be laid off.	Up to 301 non-clinical FTEs could be laid off.
Renovation Costs	$915,967	$2,072,300
Anticipated Operating Savings (net of renovations)	$5,373,320 (based on 12 months)	$8,490,647 (based on 12 months)

Changes	**Crownsville Closure: 200 patients relocated as follows**
Spring Grove	100 patients; creates 4 units: adolescent, forensic admissions, forensic intermediate, intermediate
Springfield	63 patients; creates 2 long-term units
Thomas B. Finan	20 adolescent patients; creates one geriatric-medical unit
Walter P. Carter	17 patients; creates one admission unit
TOTAL	200 patients = 8 new units

Changes	**Spring Grove Closure: 250 patients relocated as follows (plus 50 Assisted Living residents – units to be privatized)**
Crownsville	100 patients; creates 5 new units: forensic admissions, forensic intermediate, med-psychiatric and two research acute units
Springfield	63 patients; creates 3 new units of intermediate care
Upper Shore	11 patients; absorbed into existing unit
Thomas B. Finan	25 patients; creates one long-term care unit and increases adolescent beds
Walter P. Carter	51 patients; creates 3 admission units
TOTAL	250 patients = 12 new units

*See Appendix iii for details.

In Appendix iii, "Budget Summary of Hospital Consolidation Plans," the anticipated savings are estimated by deducting certain expenditures from the consolidating/closing facility's budget. These include staff costs (salaries and fringe associated with the transferring staff), operating costs (which include everything minus staff salaries/fringe), and renovation costs (costs associated with renovating the units to accommodate patients transferring into that facility). In addition to these costs, there would be some funds needed (as noted in Appendix iii) to provide community supports enabling patients ready for hospital discharge to move into appropriate community settings. In the consolidation/closure of Spring Grove Hospital, there would be expenditures associated with the relocation of State tenants and the Maryland Psychiatric Research Center.

Privatization

Walter P. Carter Center (WPCC) is located in downtown Baltimore City. The Carter Center currently operates an acute inpatient facility serving a daily population of 49 acute care patients. These individuals are treated and discharged and/or moved to longer-term units in other facilities as appropriate. WPCC has the physical capacity to open three more wards, adding 51 beds. In addition, WPCC provides a triage function for admissions to the State system and assists emergency rooms in locating psychiatric beds for patients in need of inpatient care. In order to maintain an optimal inpatient operation and allow patients to move through the system, the WPCC length of stay should be no more than 30 days.

Many of the clinical services at the Carter Center are staffed by contractual arrangements through the University of Maryland Medical System. The current location, structures, and function of WPCC make it a viable candidate for privatization. Privatization would offer many advantages. It would provide flexibility in the Central Maryland area, which would become essential if the IMD Waiver is lost. Maryland and the Department have a history of successful private-public partnerships. For example, the transfer governance of Montebello Hospital Center to University of Maryland, Kernan Hospital has been beneficial programmatically and fiscally. Given the physical proximity and the professional relationship with the University of Maryland, DHMH proposes that the University of Maryland assume governance of the Carter Center. Under such a privatization arrangement, it may be necessary for DHMH to subsidize uncompensated care through a contract.

An additional option to be explored is moving all acute care to the private sector. The Department will review this option further after resolution regarding the consolidation of the hospitals.

Recommendations and Conclusion

The Department concurs that consolidation/closure of one facility is possible. Issues of concern are continuity of care, geographic access for patients to community service providers, family involvement in treatment, layoffs and potential increased staff shortages due to staff reluctance to relocate. The logistics of and costs associated with relocation of campus tenants are also difficult issues. Although, as noted, there are concerns related to consolidation/closure of any facility, the consolidation/ closure of Crownsville is the most logical option. Consolidation/closure of Crownsville Hospital Center is possible through the utilization of available bed capacity within the system. It is estimated that it would take approximately twelve (12) months to implement the consolidation/closure, allowing for the completion of renovations and staggered transitioning of both patients and staff (see

attached timeline chart found in Appendix v). Additionally, it is recommended the Walter P. Carter Center be privatized, continuing the downsizing of the State system and creating greater flexibility within the system in the future.

In addition to the privatization and consolidation/closure recommendations, it is further recommended that other reconfiguration options involving privatization be examined. Currently, the private sector operates acute care beds and some intermediate care beds. With adequate funding and appropriate incentives, the private sector may be willing to absorb all of the acute care business, leaving intermediate and long-term care to the State. This may be a more appropriate role for the State. Privatization of the Walter P. Carter Center may be the first step in this direction. Privatization of the RICAs (RTCs for children and adolescents) should be considered as well. The Governor's Office for Children, Youth and Families (OCYF) is currently studying the RTC system.

The Department remains available to continue working with the General Assembly on the reconfiguration options. The table entitled, "Final Bed Plan" found in the Appendix ii, provides the final configuration of the hospital system of care detailed in this report.

APPENDICES

CURRENT BED CONFIGURATION

Mental Hygiene Administration Psychiatric Facilities

Facility	*Current Available Bed Capacity	Capacity Available After Crownsville Closure	FY 2003 Budgeted Beds	FY 2003 Average Daily Population	Net Available Bed Capacity**
Walter P. Carter Center	84	84	49	49	33
Crownsville Hospital Center	324	0	202	197	
Eastern Shore Hospital Center	80	80	78	74	4
Thomas B. Finan Center	119	119	80	74	43
Clifton T. Perkins Hospital Center	250	250	206	217	28
Spring Grove Hospital Center	415	415	277	273	134
Springfield Hospital Center	358	358	275	267	84
Upper Shore Community Mental Health Center	64	64	37	37	26
SubTotals	**1,694**	**1,370**	**1,204**	**1,188**	**352**
Spring Grove Hospital Center – Assisted Living Beds	70	70	50	46	23
Springfield Hospital Center- Assisted Living Beds	53	53	53	43	9
Mental Hygiene Administration Total Beds	**1,817**	**1,493**	**1,307**	**1,277**	**384**

*Current available bed capacity is the number of licensed beds that meet physical and program standards, applicable codes and are physically available for use (may need some renovation). Numbers based on 2003 Facility Inventory as approved by the CEO of each facility.

**Based on 98% occupancy rate for bed capacity, less FY 2003 census

Source: Office of Planning and Capital Financing – FY 2003 Facility Inventory
HMIS Statistical Reports: Operated Capacity/Budgeted Beds is number of beds in building in use; and ADP

Final Bed Plan

Mental Hygiene Administration Psychiatric Hospitals

Number of Beds and ADP by Facility

FACILITY	Bed Level FY 2003 Budgeted Beds	Bed Level FY 2003 ADP	Future Bed Level Final Bed Count	Future Bed Level **ADP
Carter Center	49	49	*66	64
Crownsville Hospital Center	202	197	-	-
Eastern Shore Hospital Center	78	74	80	78
Thomas B. Finan Center	80	74	100	98
Clifton T. Perkins Hospital Center* **	206	217	254	248
Spring Grove Hospital Center	277	273	377	369
Springfield Hospital Center	275	267	338	331
Upper Shore Community Mental Health Center	37	37	37	36
Total:	**1,204**	**1,188**	**1,252**	**1,224**

**Privatization of Carter is a proposed option. If this option would be accepted, the additional beds and resources would be moved to Spring Grove Hospital.*

*** Based on 98% occupancy.*

****Assumes new 48-bed maximum security unit available for occupancy September 06 for all mental health patients. Final budget beds will increase to 274 beds after DDA forensic unit moves to the new 54 bed forensic building in the fall of 2006.*

Budget Summary of Hospital Consolidation Plans
Additional Costs for the Hospital

	# of Patients	Staffing Costs	Operating Costs	Renovation Costs	Total Costs
Crownsville Option					
Spring Grove	100	8,442,034	1,682,500	600,000	10,724,534
Springfield	63	4,984,145	1,095,300	200,000	6,279,445
Finan	20	1,703,449	480,900	40,000	2,224,349
Carter	17	1,793,745	458,910	75,967	2,328,622
Upper Shore	-	-	-	-	-
Crownsville	-	500,815	900,000	-	1,400,815
Community		-	5,000,000	-	5,000,000
Total	200	17,424,187	9,617,610	915,967	27,957,764
Crownsville Current Budget					33,331,084
Total Costs w/closure					27,957,764
Anticipated FY05 Savings					5,373,320
Renovation Costs					915,967
Anticipated FY06 Savings (ongoing)					6,289,287
*Savings (net of renovations)					$5,373,320
Spring Grove Option					
Crownsville	100	8,442,034	1,682,500	480,000	10,604,534
Springfield	63	4,984,145	1,095,300	200,000	6,279,445
Finan	25	1,703,449	591,750	40,000	2,335,199
Carter	51	4,980,144	1,287,690	189,000	6,456,834
Upper Shore	11	865,844	259,235	63,300	1,188,379
Assisted Living	50	-	3,942,000	-	3,942,000
Spring Grove	-	743,852	1,100,000	-	1,843,852
Office Space		-	1,200,000	500,000	1,700,000
MPRC Space		-	2,000,000	600,000	2,600,000
Community		-	5,000,000	-	5,000,000
Total	300	21,719,467	18,158,475	2,072,300	41,950,242
Spring Grove Current Budget					50,440,889
Total Costs w/closure					41,950,242
Anticipated FY05 Savings					8,490,647
Renovation Costs					2,072,300
Anticipated FY06 Savings (ongoing)					10,562,947
*Savings (net of renovations)					$8,490,647

*Based over a 12 month period; less than 12 months = less savings.

CLOSURE OPTIONS
PROS AND CONS

Spring Grove Hospital Center Consolidation/Closure

PRO

- Savings to State is higher: $8,490,647 verses $5,373,320
- Privatization of two assisted living units may facilitate Medicaid eligibility and thereby reimbursement, and enhances private-public partnerships
- Campus is the oldest and in need of modernization and renovation at higher costs to the State

CON

- Staff Issues:
  - Greatest number of potential non-clinical lay-offs: 301 verses 147
  - Loss of public transportation to assist staff and families traveling to/from facility
- Tenant Issues:
  - Need to relocate tenants at a higher cost for new space
  - Direct cost to DHMH related to DHMH tenants (e.g., Office of Health Care Quality, Dental Board, Alcohol and Drug Abuse Administration, Mental Hygiene Administration)
  - Maryland Psychiatric Research Center needs proximity to facility as well as to the University of Maryland; direct cost to State for relocation of MPRC.
- Patient Issues:
  - Greatest number of patients would leave Central Maryland, which impacts on family involvement
  - 25% of patients in two long-term units would lose continuity of care with treatment teams
  - Advanced somatic care not available at any other facility
- Building/Campus Issues:
  - 69 out of 75 buildings currently in use (tenant and patient buildings, powerplant/maintenance, etc.)
  - Campus is the oldest psychiatric hospital in the United States, historical value, buildings cannot be torn down
  - Less acreage available–campus has numerous wetlands, unable to build on protected areas, less value as "real estate"
  - Smith Building is the only "state-of-the-art" medical-surgical building within State psychiatric hospital system; to move it would require construction costs
  - MPRC laboratory space would need to be relocated; costs associated could be significant

Pros & Cons (continued)

Crownsville Hospital Center Consolidation/Closure

PRO

?? Least number of patients affected by transfer
?? Greater number of patients would stay in Central Maryland region: 90% verses 85%
?? 50% of patients would be transferred to Spring Grove Hospital, where public transportation is available
?? Tenants are private entities and are independent or less dependent on CHC's utilities/maintenance support, thereby, less financial impact to State
?? Least number of potential lay-offs: 147 verses 301

CON

?? Staff Issues:
    ?? Staff may not opt to transfer with patients, vacancies resulting in increased recruitment issues
    ?? 147 non-clinical FTEs could potentially be laid off
?? Tenant Issues:
    ?? Displacement issues for private entities; relocation of some tenants may not have community support (e.g., alternative high school, day care program, KOBA Institute, Second Genesis)
?? Patient Issues:
    ?? Greater distance to travel may impact on patient's family supports
?? Building/Campus Issues:
    ?? Medical & Surgical unit needs extensive renovations to accommodate additional patients and staff

CONSOLIDATION ACTIVITY & 12-MONTH TIMETABLE	1	2	3	4	5	6	7	8	9	10	11	12
Preliminary Steps												
?? Hire a Closure Coordinator for closing facility.	X											
?? Notification of patients, staff, family, advocates, local community, Delegates, Senators, Provider Community.	X											
?? Renovation plans start at receiving facilities.	X											
?? Letters to employees offering them a position at the receiving facility, indicating timelines for responses.		X	X									
?? Schedule regular meetings w/employees on progress.	X	X	X	X	X	X	X	X	X	X	X	X
Patients												
?? Decide which patients will move to what hospital/unit.			X									
?? Notify family (Contingent on everything going as planned.)			X									
?? Establish bi-weekly meetings with the families involved to share issues and update progress.			X	X	X	X	X	X	X	X	X	X
Tenants												
?? Determine when and if tenants have to move.		X	X									
?? Continue with renovations.	X	X	X	X	X	X	X	X	X	X	X	X
?? Schedule regular meetings on progress.	X	X	X	X	X	X	X	X	X	X	X	X
Staff												
?? Establish needed staffing patterns.			X									
?? Compile list of how many staff will be moving with patients.			X									
?? Establish monthly newsletter to let staff know progress.		X	X	X	X	X	X	X	X	X	X	X
?? Have contingent plans for consolidating units if staff starts to resign/retire.		X	X	X	X	X	X	X	X	X	X	X
?? Hire the extra staff needed for new unit.										X	X	X
?? Have staff at receiving unit trained and ready to integrate with existing staff.											X	X

Continued…CONSOLIDATION ACTIVITY & 12-MONTH TIMETABLE	1	2	3	4	5	6	7	8	9	10	11	12
Dietary												
?? Have Dietary start to plan on bringing up additional meals.								X	X			
?? Hire additional dietary staff if necessary.										X	X	X
?? Get list of special diets of new patients.										X	X	
?? Order additional food.										X	X	X
Carter Center unit up and running. Stop admissions to closing hospital.								X	X			
Equipment												
?? Inventory all equipment at facility.					X	X						
?? Assess furniture at closure hospital.					X	X	X					
?? Establish list of new equipment needs.								X	X			
?? P.O. for furniture and equipment, i.e., washers and dryers.									X			
?? Decide what will be surplus and offer to receiving facilities.							X					
?? Depending on season – stop buying oil.			X	X								
?? Check dietary inventory – determine on spend down pattern.									X	X		
?? Continue renovations.	X	X	X	X	X	X	X	X	X	X	X	X
Lay-Off Notices												
Hand out lay-off notices.										X		
Units Ready												
Renovations Complete.										X	X	X
Move the first unit to new location.											X	
Furniture to be moved same day as patients. (if necessary)											X	
Other facilities to help with movement of furniture.											X	
Meet to determine problems to work out before next unit moves.											X	
Move 1 unit of patients every week till end of 12 month.											X	X
All staff that move with patients should be given as much support as possible and a token of remembrance from the facility they moved from.											X	X
Secure closed facility.												X

Crownsville Hospital Center

Tenant List

Building	Tenant	Square Footage Utilized	# of Clients / Staff Occupying Building
"A" Building	Anne Arundel County Food Bank	22,616	11
	Historic Annapolis	5,000	N/A (Storage)
Superintendent's Mansion	Adventist Healthcare, Inc.	9,372	19
Cottages 15	Adventist Healthcare, Inc.	16,250	65
Cottages 16	Adventist Healthcare, Inc.	16,250	25
Phillips Building	Second Genesis	40,319	120
Phillips Building Annex	Second Genesis	12,000	30
"C" Building	Chesapeake PC Users Group, Inc.	4,000	5
	Parole Rotary's International Book Project		5
Male Dormitory	Hope House	21,654	76
5 acres near Campanella building	KOBA Institute erected several trailers for their level V school	N/A	30
*** Firehouse**	Maryland Underwater Archeology	1,000	2
*** Winterode Building**	Alternative High School/ Anne Arundel County Police Crime Lab	N/A	215
*** Erected their own building**	Habitat for Humanity	N/A	N/A(Storage)
	Day Care program	N/A	123
	Dept Housing and Community Development	N/A	450

* Non-tenants on grounds using some CHC utilities

Note: Fairfield Nursing Home and Chrysalis House use CHC water and sewage, but is not a tenant and is not on CHC property.

Spring Grove Hospital Center
Tenant List

Building	Tenant	Square Footage Utilized	# of Clients / Staff Occupying Building
Benjamin Rush	Board of Dental Examiners	4,131	12
Benjamin Rush	Board of Occupational Therapy	565	4
Voc. Rehab	Alcohol and Drug Abuse Administration (ADAA)	11, 138	68
Dix & Mitchell	Mental Hygiene Administration (MHA)	39,700	72
Bland Bryant	Office of Health Care Quality	76, 400	183
MD Psychiatric Research Center & White (MPRC)	University of Maryland	41, 500	200
Cottage 12	Financial Agents	2, 100	8
Stone Cottage E	The Free State Theatre Organ Society	14, 400	18
Garrett	The SGHC Alumni Museum	4, 435	12
Jamison/Canteen	The SGHC Auxiliary	10, 500	25 Volunteers
Cottages #5 & #13	Medical Student Housing/Training	4, 200	11 Students rotating in 6 week intervals
Amer House	The DICK Corp (Contractors for SHA)	2, 000	70

* All tenants use SGHC utilities; all tenants, with the exception of the Amer House, are dependent upon the SGHC central steam system (heating and hot water).